VIRGINIA MEDICAID PHARMACIST INTERVENTION REPORT FORM

This form should be used to document interventions needed to resolve problems identified through prospective DUR screening. **Only those issues that in the judgement of the pharmacist are of *moderate to high clinical significance* or involve *significant cost savings* need be documented.** It is anticipated that approximately 2-4% of Medicaid recipients' prescriptions will involve the need to resolve issues of this magnitude.

The use of this form is voluntary. The data from the intervention reports will be used to assess the validity of the prospective DUR criteria and to estimate the economic value of cognitive services provided by pharmacists.

Completed forms should be forwarded to the DUR Program Consultant by mail or by fax at least weekly. If desired, forms may be submitted as they are completed. Call (804) 786-3820 if you have any questions about this form.

Pharmacy Medicaid ID Number:		**Patient Medicaid ID Number:**
Date:	**RPh Name:**	**Prescription Number (If applicable):**

TYPE OF INTERVENTION -- *Check ONE type of intervention; list the drug(s), contraindications and other pertinent details below*

Drug Interactions/Contraindications

- ☐ 121 Drug-drug interaction
- ☐ 122 Duplicate therapy
- ☐ 123 Drug-allergy interaction
- ☐ 124 Drug-age/gender contraindication
- ☐ 125 Drug-disease contraindication

Other Therapeutic Problems

- ☐ 131 Apparent underutilization
- ☐ 132 Apparent overutilization
- ☐ 133 Potential abuse
- ☐ 134 Therapeutic appropriateness
- ☐ 139 Other: _____

Dosing Adjustment Recommendations

- ☐ 141 Decrease in total daily dosage
- ☐ 142 Increase in total daily dosage
- ☐ 143 Decrease in duration of therapy
- ☐ 144 Increase in duration of therapy
- ☐ 149 Other: _____

Drug(s) and Contraindications Involved:

ACTION TAKEN -- *Check ONE box only*

With Whom Did You Communicate to Make Your Recommendation?

- ☐ 221 Recipient or Agent
- ☐ 222 Prescriber
- ☐ 223 Recipient (or Agent) and Prescriber
- ☐ 229 Other: _____

RESPONSE TO RECOMMENDATION -- *Check ONE box in EACH section*

Accepted by Recipient or Agent?

- ☐ 321 Yes
- ☐ 322 No
- ☐ 323 Not known
- ☐ 329 Not applicable

Accepted by Prescriber?

- ☐ 331 Yes
- ☐ 332 No
- ☐ 333 Not known
- ☐ 339 Not applicable

OUTCOME OF INTERVENTION -- *Check ONE box in EACH section; describe adverse/side effect or lack of efficacy as needed*

Patient Experienced Adverse or Side Effects

- ☐ 421 Yes: _____
- ☐ 422 Possible
- ☐ 423 No
- ☐ 424 Not known
- ☐ 429 Not applicable

Patient Experienced Lack of Efficacy

- ☐ 431 Yes: _____
- ☐ 432 Possible
- ☐ 433 No
- ☐ 434 Not known
- ☐ 439 Not applicable

MAIL THIS FORM TO:

DUR Program Consultant, QCA/MS
Dept of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

OR FAX TO: (804) 371-4986
NOTE: No cover sheet is necessary; transmit after 5 pm if possible.

COMMENTS:

DMAS - 175 R 1/93